DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152639	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/25/2012

NAME OF PROVIDER OR SUPPLIER **RUSH COUNTY DIALYSIS**	STREET ADDRESS, CITY, STATE, ZIP CODE **1400 N CHERRY ST** **RUSHVILLE, IN 46173**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{V 000}	INITIAL COMMENTS This visit was a revisit for a ESRD recertification survey completed May 23, 2012. Survey date: June 25, 2012 Facility #: 012064 Medicaid Vendor #: 200942310 Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor During this survey, 3 Conditions for Coverage and 24 standard level deficiencies were found corrected. Rush County Dialysis is in compliance with the Conditions for Coverage for End Stage Renal Disease facilities 42 CFR Part 494. Quality Review: Joyce Elder, MSN, BSN, RN June 27, 2012	{V 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.